California State Board of Pharmacy
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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GRAY DAVIS, GOVERNOR

DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF PHARMACY
SOUTHERN COMPLIANCE COMMITTEE MEETING
MINUTES

DATE:	February 22, 2000
TIME:	11:00 a.m. - 3:20 p.m.
LOCATION:	Van Nuys State Building Auditorium 6150 Van Nuys Boulevard Van Nuys, CA 91401
BOARD MEMBER PRESENT:	Holly Strom, Chairperson John Jones, Board Member Robert Elsner, Board Member
STAFF PRESENT:	Robert Ratcliff, Supervising Inspector Gilbert Castillo, Supervising Inspector De'Bora White, Pharmacy Inspector Robert Venegas, Pharmacy Inspector Linda Kapovich, Enforcement Technician
ALSO PRESENT:	Farid Raphael Pourmorady, RPH, PIC Larisa Fayman, RPH Norma Leynes Coronell, RPH Gary Fong, RPH Johnny Dong, RPH Joohwa Park, RPH Claire Elias, RPH Steven A. Levin, RPH May Yam, RPH Mehran Ravaei, RPH Margo Sobol, RPH Bruce Wiswell, Pharmacy Development Manager

Ismail Keekeebhai, Pharmacy Development Manager
Richard Martland, Attorney at law
Morad Fred Hajaliloo, Regional Pharmacy Manager
Jerome Newman, Acquisition Pharmacy Manager
Richard Pilsl, RPH, PIC
Mi Sook Bae, RPH
Paul Wood, RPH
Claude Barakat, RPH, PIC
Ray Sako, Regional Pharmacy Manager
Harold Adelman, RPH, PIC, Owner
Hautak Yu, RPH, PIC
Elmo Pratt, RPH
Barbara Gee, Regional Pharmacy Manager
Bob Miller, System Director of Pharmacy
John Howard, Director of Pharmacy
Terry Webb, Director of Pharmacy
Kirt K. Patel, Division Pharmacy Sales Manager
Tim Wee, RPH, PIC, Pharmacy Manager
Mark LeHew, RPH, PIC, Owner

CALL TO ORDER

Chairperson Holly Strom called the meeting of the Southern Compliance Committee to order at 11:00 a.m.

A. DISCIPLINARY APPEARANCES

1. Farid Raphael Pourmorady — CI 1996 13765
RPH 44247, PIC

Larisa Fayman
RPH 48325

Norma Leynes Coronell
RPH 40919

Gary Fong
RPH 48840

Johnny Dong
RPH 45618

Joohwa Park
RPH 42530
Claire Elias
RPH 45132

Steven A. Levin
RPH 46443

May Yam
RPH 45023

Mehran Ravaei
RPH 42480

Margo Sobol
RPH 49000

Thrifty Drug Store #6030
Los Angeles, CA
PHY 38347

Bruce Wiswell, Pharmacy Development Manager
Ismail Keekeebhai, Pharmacy Development Manager
Richard Martland, Attorney at law

Farid Raphael Pourmorady, Larisa Fayman, Norma Leynes Coronell, Gary Fong, Johnny Dong, Joohwa Park, Claire Elias, Steven A. Levin, May Yam, Mehran Ravaei, Margo Sobol and Thrifty Drug Store #6030 were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that Larisa Fayman failed to give oral consultations on new prescriptions. All eleven pharmacists were filling controlled substance prescriptions, some at irrational intervals. These prescriptions were forgeries. Some records were not maintained and were not available. Some of the pharmacists were failing to use the system to alert clerks to call a pharmacist when patient consultations were indicated. The pharmacy does not have a system to alert the pharmacist to suspicious prescriptions. The pharmacists do not regularly review the patient's medication profile.

On December 12, 1996 a violation notice was issued to Thrifty Drug #6030, Larisa Fayman and Raphael Pourmorady for violation of:

- Business and Professions Code section 4301 – Unprofessional conduct.
- California Code of Regulations section 1707.2 – Duty to consult.
- California Code of Regulations section 1707.3 – Duty to review drug therapy and patient medication record prior to delivery.
- Business and Professions Code section 4081 – Records of dangerous drugs and devices to be kept open for inspection; maintenance of records, and current inventory.
- Health and Safety Code section 11153 – Responsibility for legitimacy of prescription; corresponding responsibility of pharmacist; knowing violation.

Mr. Pourmorady stated that he had informed the board inspector that the prescription was marked for consultation. All new prescriptions or refills that required a change were marked with a large read "C". He also stated that to insure all patients' receive consultation, an intern or pharmacist take in all new prescriptions. This allows the pharmacists to begin the consultation process right from the start.

Ms. Fayman stated that she knows that it is very important to consult on all new prescriptions or when a change has been made on a refill. Ms. Fayman explained that in this case, she approached the patient incorrectly by asking the patient if she had taken the medication before. Ms. Fayman stated she has changed her method of patient consultation, and no longer begins her consultation with a question.

The committee advised all present never to ask the patient if they have any questions regarding the medication they are picking up. The committee suggested a better way is to ask the patient if they know why their doctor prescribed the medication they are picking up. This will allow the pharmacist to learn what the patient already knows, and to determine what else the patient needs to know.

Mr. Pourmorady responded that the pharmacy now uses a green consultation sticker. If it is a new prescription or there is any kind of a change on a refill prescription a green sticker is

placed on the prescription. All of the pharmacy staff is aware of when to use the green stickers and to call a pharmacist for consultation before the medication is dispensed to the patient.

The committee expressed concern as to how so many forged prescriptions were filled at the pharmacy.

Mr. Pourmorady responded that the pharmacy was a victim. When the board inspector brought the forgeries to the attention of the pharmacy staff, no further prescriptions were filled for that patient. Mr. Pourmorady added that the prescribing physician was notified, and all of the pharmacy staff were made aware of the problem.

The committee asked Mr. Pourmorady if a new patient came into the pharmacy with a new prescription, how would he verify that the prescription was a valid one.

Mr. Pourmorady responded that the first thing he would do was to make sure that the prescription was an original and not a photocopy. Second he would call the prescribing physician to verify that he or she wrote the prescription.

Mr. Levin added that he has never knowingly filled a forged prescription. He explained that he has always verified all questionable prescriptions with the prescribing physician.

The committee warned those present that if the patient and the prescribing physician were both from out of the area the pharmacy should always be suspicious of the legitimacy of the prescription.

The committee asked those present if the patient were paying cash would the computer system still warn that the prescription is being filled too soon.

Mr. Keekeebhai responded that yes it would.

Mr. Wiswell stated that since this incident occurred Rite Aid has changed computer systems.

The committee admonished those present with regard to the amount of acetaminophen dispensed in a 48-hour period. The committee stated that this is a pharmacist's basic clinical function to know the maximum dosage of acetaminophen for a 24-hour period.

M/S/C: Strom/Jones

The committee accepted the appearance of Farid Raphael Pourmorady, Larisa Fayman, Norma Leynes Coronell, Gary Fong, Johnny Dong, Joohwa Park, Claire Elias, Steven A. Levin, May Yam, Mehran Ravaei, Margo Sobol and Thrifty Drug Store #6030; (a) the matter will be

made a part of the record of Farid Raphael Pourmorady, RPH 44247, Larisa Fayman, RPH 48325, Norma Leynes Coronell, RPH 40919, Gary Fong, RPH 48840, Johnny Dong, RPH 45618, Joohwa Park, RPH 42530, Claire Elias, RPH 45132, Steven A. Levin, RPH 46443, May Yam, RPH 45023, Mehran Ravaei, RPH 42480, Margo Sobol, RPH 49000, and Thrifty Drug Store #6030; (b) Farid Raphael Pourmorady, RPH 44247, Larisa Fayman, RPH 48325, Norma Leynes Coronell, RPH 40919, Gary Fong, RPH 48840, Johnny Dong, RPH 45618, Joohwa Park, RPH 42530, Claire Elias, RPH 45132, Steven A. Levin, RPH 46443, May Yam, RPH 45023, Mehran Ravaei, RPH 42480, and Margo Sobol, RPH 49000, are each to write a letter explaining how he or she would determine the validity of a prescription. This letter is to be mailed to the attention of Robert Ratcliff no latter than 30 days from this meeting. No further action will be taken at this time.

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2. Richard Pilsl CI 1997 15273
RPH 41329, PIC

Mi Sook Bae
RPH 44909

William Nabeel BiChai
RPH 40316

Paul Wood
RPH 24736

Rite Aid #5425
Los Angeles, CA
PHY 42434

Bruce Wiswell, Pharmacy Development Manager
Ismail Keekeebhai, Pharmacy Development Manager
Richard Martland, Attorney at law
Fred Hajalilioo, Pharmacy Director for Ralphs

Richard Pilsl, Mi Sook Bae, William Nabeel BiChai, Paul Wood, and Rite Aid #5425 were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that in October of 1997 Rite Aid #5425 dispensed Levoxyl on a prescription calling for Synthroid. The dispensing pharmacist was never identified, RPH BiChai was the pharmacist-in-charge during the incident.

In June of 1998, during an inspection, RPH Wood was found to be supervising two interns and two technicians at the same time. In addition it was also determined during the inspection that Rite Aid #5425 had not notified the board of a change in pharmacist-in-charge.

On June 18, 1998 a violation notice was issued to Rite Aid #5425, William Nabeel BiChai, Mi Sook Bae, and Paul Wood for violation of:

- Business and Professions Code section 4301 – Unprofessional Conduct
- Business and Professions Code section 4076 (a) (1) – Except where the prescriber orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used…
- Business and Professions Code section 4076 (a) (9) - The expiration date of the effectiveness of the drug dispensed.
- California Code of Regulations section 1793.7 – Requirements for pharmacies employing pharmacy technicians.

- Business and Professions Code section 4113 – Pharmacist in charge: Notification to the board; responsibilities.
- Business and Professions Code section 4333 – Maintaining prescriptions, other drug records on premises, open to inspection.
- California Code of Regulations section 1717(g) – The pharmacy must have written procedures that identify each individual pharmacist responsible for the filling of a prescription and a corresponding entry of information into an automated data processing system, or a manual record system, and the pharmacist shall create in his/her handwriting or through hand initialing a record of such filling, not later than the beginning of the pharmacy's next operating day. Such record shall be maintained for at least three years.

William Nabeel BiChai was excused from this appearance and will be heard at a future meeting of the Southern Compliance committee.

Ms. Bae explained when she worked as PIC at the pharmacy she completed the change of pharmacist-in-charge forms and mailed them to the corporate office.

The committee admonished Ms. Bae, stating that it is her responsibility to notify the board when she accepted the position and when she terminated her employment as PIC.

Mr. Wiswell explained that he has been working closely with board staff to rectify the errors made in processing the change of PIC paperwork. Mr. Wiswell commended the board staff for their efforts in resolving this issue. Mr. Wiswell announced that he is very close to being caught up.

The committee expressed concern regarding the pharmacy's use of arbitrary expiration dates on the prescription labels.

Mr. Wiswell responded that the RADS computer will automatically put an arbitrary date on the label, however, the pharmacist is allowed to override the date, especially on suspensions. On oral suspensions there is an extra label for the pharmacist to hand write in the expiration date.

The committee admonished those present, stating that the use of arbitrary expiration dates is a violation of pharmacy law and the pharmacist should use professional judgement in establishing the expiration date for a medication.

Mr. Pilsl stated that he no longer works at this pharmacy, he is currently PIC at Rite Aid store #5462.

M/S/C: Strom/Jones

The committee accepted the appearance of Richard Pilsl, Mi Sook Bae, Paul Wood, and Rite Aid #5425; (a) the matter will be made a part of the record of Richard Pilsl, RPH 41329, Mi Sook Bae, RPH 44909, Paul Wood, RPH 24736, and Rite Aid #5425, PHY 42434; (b) a follow up inspections at both Rite Aid store #5425, PHY 42434 and Rite Aid store #5462, PHY 42629 to check for arbitrary expiration dates and staff identification badges. No further action will be taken at this time.

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3. Claude Barakat CI 1998 16274
RPH 39018, PIC

Vons Pharmacy #2655
Los Angeles, CA
PHY 43028

Ray Sako, Regional Pharmacy Manager

Claude Barakat and Vons Pharmacy #2655 were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that RPH Barakat dispensed Hydrocodone/Homatropine syrup on a prescription written for Robitussin AC syrup (Guaifenesin with Codeine). The complainant stated that he did not receive consultation from the pharmacist. During an inspection of the pharmacy patient consultation was observed.

On June 10, 1999, a violation notice was issued to Claude Barakar and Vons Pharmacy #2655 for violation of:

- Business and Professions Code section 4301 – Unprofessional conduct.
- California Code of Regulation section 1716 – Variation from prescription.

On November 2, 1999, a violation notice was issued to Claude Barakat and Vons Pharmacy #2655 for violation of:

- California Code of Regulations section 1707.2 Duty to consult.

This investigation also charges Claude Barakat and Vons Pharmacy #2655 for violation of:

- Business and Professions Code section 4076 – Prescription container and requirements for labeling.

Ms. Barakat stated that the computer had been programmed incorrectly at the corporate level and that the computer substituted the Homatropine as a generic replacement for the Robitussin AC.

The committee expressed concern as to how the computer could be incorrectly programmed.

Mr. Sako responded that he could not explain how the error occurred, and explained that the error was made in the corporate office, not at the pharmacy level.

The committee requested a copy of the written policy and procedure for the discovery of a computer anomaly, this policy should include how to report this to the corporate office, and how the error is corrected in the pharmacy. The committee also requested to see a written policy and procedure for how the pharmacy handles a prescription error. These policies are to be mailed to the board office within 30 days.

The committee expressed concern with regard to the complainant's statement that he did not receive patient consultation.

Ms. Barakat responded that she could not remember what she would have done at the time of the incident. Ms. Barakat explained that at this time, during consultation she would have held the bottle and gone over the dosage instructions and warned the patient of the possible side effects.

The committee expressed concern with regard to how Ms. Barakat missed that the medication was labeled Homeatropine.

Ms. Barakat responded that she is not sure if the consultation occurred or not.

The committee suggested that Ms. Barakat bring the original prescription document with her to the counter to perform the patient consultation, and that she check the original prescription against the prescription label to check for accuracy.

M/S/C: Strom/Jones

The committee accepted the appearance of Claude Barakat and Vons Pharmacy #2655; (a) the matter will be made a part of the record of Claude Barakat, RPH 39018, and Vons Pharmacy #2655, PHY 43028; (b) Claude Barakat, RPH 39018 is cited and fined $250., for failure to provide patient consultation as required; (c) Vons Pharmacy #2655, PHY 43028, is cited and fined $1,000., for failure to provide patient consultation as required; (d) Mail the board a copy of the written policy and procedures for reporting and correction of computer anomalies and for reporting prescription errors within 30 days. No further action will be taken at this time.

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4. Hautak Yu CI 1999 17808
RPH 36662, PIC

Elmo Pratt
RPH 28875

Sav-On Drugs #3708
Lancaster, CA
PHY 41501

Barbara Gee, Regional Pharmacy Manager

Supervising Inspector Robert Ratcliff recused himself from this hearing.

Hautak Yu, Elmo Pratt, and Sav-On Drugs #3708 were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that on June 15, 1999, RPH Pratt dispensed Alphagan on a prescription calling for Optichrom. The patient's mother indicated that she did not receive consultation on this prescription. The medications are for very different uses and effective consultation might have prevented this prescription error.

On October 28, 1999, the inspector made an inspection of the facility and issued a violation notice to Elmo Pratt and Sav-On Drugs #3708 for violation of:

- Business and Professions Code section 4301 – Unprofessional conduct.
- California Code of Regulations section 1716 – Variation from a prescription.
- California Code of Regulations section 1707.2 – Duty to consult.

Mr. Yu stated that he did not state to the board inspector that the error would have been discovered with effective consultation. He explained that the board inspector stated that the error would have been discovered with effective consultation, and Mr. Yu just agreed with the inspector's statement.

Mr. Yu further explained that he reviewed the consultation log and consultation did occur at the time of the incident. Mr. Yu explained that the technician as well as the pharmacist signs the consultation log. Mr. Yu stated he feels this is added proof that consultation was performed. Mr. Yu added that the consultation may have been inappropriate, but it was provided.

Mr. Pratt stated that he is now working at Sav-On #3285, in fact he has worked in several locations since the time of this error and he could not recall this incident. He added that he has read the documents to refresh his memory, but that is all he has to go on.

The committee asked Mr. Pratt, at the time the incident occurred did the pharmacy's computer system have the ability to recognize a pediatric patient form a geriatric patient.

Mr. Pratt responded that the computer prints a short history on the patient, which includes the date of birth and other pertinent medical information.

Ms. Gee added that this information is kept with the original prescription until the medication is dispensed to the patient.

The committee asked those present to explain when the pharmacist reviews the patient's medication profile.

Mr. Yu responded that the technician reviews the medication profile when the prescription is entered into the computer system.

Mr. Pratt added that he would pull up the patients profile if he thought that the patient had a history at the pharmacy.

The committee asked those present if the Sav-On computer system has any age warnings.

Ms. Gee responded that it does not.

M/S/C: Strom/Jones

The committee accepted the appearance of Hautak Yu, Elmo Pratt, and Sav-On Drugs #3708; (a) the matter will be made a part of the record of Hautak Yu, RPH 36662, Elmo Pratt, RPH 28875, and Sav-On Drugs #3708, PHY 41501; (b) Hautak Yu, RPH 36662, PIC, is cited and fined $750, for failure to provide patient consultation as required, and failure to review the patients medication profile prior to dispensing medication; (c) Elmo Pratt, RPH 28875, is cited and fined $750, for failure to provide patient consultation as required, and failure to review the patients medication profile prior to dispensing medication; (d) Sav-On Drugs #3708, PHY 41501, is cited and fined $1,000, for failure to provide patient consultation as required, and failure to review the patients medication profile prior to dispensing medication. No further action will be taken at this time.

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5. Harold Adelman CI 1997 15277
RPH 25828, PIC, Owner

#1 Drugs
Lancaster, CA
PHY 39875

Ray Sako, Regional Pharmacy Manager

Board member John Jones recused himself from this hearing.

Harold Adelman and #1 Drugs were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that RPH Adelman did not keep complete and accurate pharmacy records. . There were 229 prescription documents missing from the pharmacy records. RPH Adelman did not record the name of the agent authorizing refills or on new telephonic prescriptions. There were 213 instances of unauthorized refills, many of which were for members of the Adelman family.

Harold Adelman and #1 Drugs are being charged in violation of:

- Business and Professions Code section 4301 (o) – Unprofessional conduct.
- Business and Professions Code section 4071 – Prescriber may authorize agent to transmit prescription: Schedule II excluded.
- Business and Professions Code section 4081 (a) – Records of dangerous drugs and devices kept open for inspection; maintenance of records and current inventory.

Mr. Adelman responded that his brother has always been his doctor. Mr. Adelman added that his brother has always written prescriptions for both him, and his family.

Mr. Adelman explained to the committee that he has a heart condition, and he only works as a relief pharmacist on the weekends at K-Mart, and a few days a week for a temporary agency and for Rite Aid.

The committee requested Mr. Adelman to explain how 229 prescription documents were missing.

Mr. Adelman responded that he did not realize that the computer system kept generating new prescription numbers every time any change was made to a prescription. Mr. Adelman explained that he failed to update the prescriptions.

The committee expressed concern as to where Mr. Adelman currently has his prescriptions filled.

Mr. Adelman responded that he fills his prescriptions at K-Mart for his heart medication. Mr. Adelman added that he also fills his wife's prescriptions.

The committee expressed concern with regards to K-Marts policy for a pharmacist filling his or her own prescriptions and the prescriptions for his or her family.

Mr. Adelman responded that he is not aware of K-Marts policy.

The committee requested a written copy of K-Marts policy and procedure on pharmacists filling prescriptions for themselves and their families.

M/S/C: Strom

The committee accepted the appearance of Harold Adelman and #1 Drugs; (a) the matter will be made a part of the record of Harold Adelman, RPH 25828, and #1 Drugs, PHY 39875; (b) a follow up visit on K-Mart in Tahachapi to ensure compliance with new prescription and refill authorization documentation, document generation, documentation of dosages given; submit to the board within 30 days, a written copy of K-Marts policy and procedure on pharmacists filling prescriptions for themselves and their families. No further action will be taken at this time.

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6. John Howard CI 1996 13482
RPH 40618, PIC

Scripps Hospital E. County
El Cajon, CA
HSP 39204

Bob Miller, System Director of Pharmacy
Terry Webb, Director of Pharmacy

John Howard and Scripps Hospital E. County were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that subject technician ordered controlled substances inappropriately and diverted them for resale. The subject was terminated from employment after confessing to the supervisor and Director of Human Resources. Investigation also revealed that the subject was convicted in municipal courts for resisting arrest, violating court order to prevent domestic violence and battery. Investigation also revealed that subject falsified application for pharmacy technician registration (failed to disclose a 1994 conviction of PC 148(a) on his March 13,1995 application.)

On November 29, 1999, a violation notice was issued to Scripps Hospital East Count, John Howard, and James Perez Venezuela for violation of:

- Business and Professions Code section 4301 (o) – Unprofessional conduct – actions or conduct that would have warranted denial of a license.
- Business and Professions Code section 4301 (g) – Unprofessional conduct – knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.
- Business and Professions Code section 4060 – Controlled substance – prescription required.
- Health and Safety Code section 11173 – Fraud, deceit, misrepresentation or false statement; false representation; false label.
- Business and Professions Code section 4081 (a) – Records of dangerous drugs and devices kept open for inspection; maintenance of records and current inventory.

Mr. Howard explained that the theft was detected when another technician reported that some Vicodin was missing. Mr. Howard explained that his investigation led him to the technician in question and that when the subject technician was confronted he confessed to the theft.

Mr. Howard explained the security measures that have been instituted to prevent this from happening again. Controlled substances classes three through five are now maintained in a locked cabinet with access restricted to pharmacists. All ordering is limited to one individual. An inventory is performed every month, and the pharmacy has obtained a Pyxis CII safe.. Mr. Howard

personally reconciles the narcotic purchasing records to the utilization reports on a quarterly basis.

The committee expressed concern as to how this technician was allowed to divert so much Vicodin.

Mr. Howard responded that the subject technician was hired prior to himself, and there were no safeguards in place to prevent the diversion.

The committee expressed concern as to why the pharmacy did not have the subject technician arrested.

Mr. Howard explained that it was the hospital administration's desire not to have the police bright in. Mr. Howard added that it is now hospital policy that anyone involved in diversion will be arrested.

The committee requested that Mr. Howard explain the pharmacy's current procedure for ordering and receiving controlled substances and dangerous drugs.

Mr. Howard explained that a technician calls in the order to the wholesaler and when the medications are delivered the technician receives them and signs for them.

The committee advised Mr. Howard that the law requires that all controlled substances and dangerous drugs and devices must be received and signed for by the pharmacist-in-charge.

Mr. Howard responded that he would change the pharmacy's procedure right away.

The committee requested that Mr. Howard send a copy of the written policy and procedures for ordering and receiving for all controlled substances to the board within fourteen days.

M/S/C: Strom/Jones

The committee accepted the appearance of John Howard, and Scripps Hospital E. County; (a) the matter will be made a part of the record of John Howard, RPH 40618, and Scripps Hospital E. County, HSP 39204; (b) within 14 days send a copy of the written policy and procedure for ordering and receiving of all controlled substances. No further action will be taken at this time.

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7. Timothy R. Wee CI 1998 17034
RPH 49478, PIC

Ainah R. Lee
RPH 44005

Albertson's Pharmacy #1632
Ridgecrest, CA
PHY 38307

Kirt K. Patel, Division Pharmacy Sales Manager

Ainah R. Lee was excused from appearing at this hearing.

This appearance was postponed to a future meeting of the Southern Compliance Committee. No further action will be taken at this time.

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8. Mark Lehew CI 1998 16259
RPH 36177, PIC, Owner

Casa Drugs
Spring Valley, CA 91977
PHY 19238

Mark Lehew and Casa Drugs were requested to appear at the Southern Compliance Committee meeting as the result of an investigation that revealed that RPH Lehew dispensed Theophylline 200mg on a prescription calling for Carbamazepine. The pharmacy does not have written policy and procedures for filling blister packs.

Mark Lehew and Casa Drugs are charged with a violation of:

- Business and Professions Code section 4301 – Unprofessional conduct.
- California Code of Regulations section 1716 – Variation from a prescription.

Mr. Lehew stated that there are several factors that lead to this error. The wholesaler changed the manufacturer. When the medication was received Mr. Lehew personally checked in the medication and entered the data into the pharmacy computer system.

The committee requested Mr. Lehew to explain the pharmacy's procedure for filling prescriptions.

Mr. Lehew explained that the pharmacy fills very few blister pack orders. The blister packs are filled just like any other prescription. The technician fills the prescription and then places the filled prescription with the stock bottle next to it in line on the counter for the pharmacist to check. Mr. Lehew added that the blister packs are too large for the stock bottle to sit in front, so it is off to the side.

The committee expressed concern as to how Mr. Lehew failed to catch the incorrect medication.

Mr. Lehew stated that he relied on the National Drug Code (NDC) number. The NDC number was one digit off and he did not catch it. He explained that he was expecting a change in the medication because the wholesaler changed the manufacturer. Mr. Lehew explained that he questioned the technician with regards to the change in the shape of the capsule. Mr. Lehew stated he could not explain how he missed the drug name on the stock bottle.

The committee asked Mr. Lehew if the pharmacy still fills blister packs.

Mr. Lehew responded that the pharmacy does occasionally fill blister packs. He stated that the pharmacy uses the same procedures and precautions that are used to fill every prescription.

The committee acknowledged that Mr. Lehew reported this medication error to the board. The committee commended Mr. Lehew and expressed their appreciation for his honesty and forthrightness.

M/S/C: Strom/Jones

The committee accepted the appearance of Mark Lehew, and Casa Drugs; (a) the matter will be made a part of the record of Mark Lehew, RPH 36177, and Casa Drugs, PHY 19238. No further action will be taken at this time.

There being no additional discussion, the meeting was adjourned at 3:20 p.m.